AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrist' services.

/X/ Provided: /__/ No limitations /X/ With limitations*

C1. Not provided.

c. Chiropractors' services.

/X/ Provided: /X/ No limitations /__/ With limitations*

/__/ Not provided.

d. Other Practitioner' Services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/__/ Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exist in area.

/X/ Provided: /__/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /__/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /__/ No limitations /X/ With limitations*

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

X Provided: ___ No limitations X With limitations*

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ Limitations*

☐ Not Provided.

c. Chiropractors' services.

☒ Provided: ☒ No limitations ☐ With Limitations

☐ Not Provided.

d. Other Practitioners' Services.

☒ Provided: Identified on attached sheet with description of limitations, if any.

☐ Not provided.

7. Home Health Services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

/XX/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

b. Dentures.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /X/ No limitations / / With limitations*

/ / Not provided.

b. Nursing facility services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Services in an Intermediate Care Faility for the Mentally Retarded

15. a. ~~Nursing facility services~~ (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

~~b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.~~

~~☒ Provided: ☐ No limitations ☒ With limitations*~~

~~☐ Not provided.~~

f. 11/1/90 **16. Inpatient psychiatric facility services for individuals under 22 years of age.**

☒ **Provided:** ☐ **No limitations** ☒ **With limitations***

☐ **Not provided.**

17. Nurse-midwife services.

☒ **Provided:** ☒ **No limitations** ☐ **With limitations***

☐ **Not provided.**

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ **Provided:** ☐ **No limitations** ☒ **With limitations***

☐ **Not provided.**

***Description provided on attachment.**

1. Inpatient Hospital Services

a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program; this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing

b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:

(a) Biopsy: breast, cervical node, cervix, lesions (skin subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
(b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
(c) Circumcision.
(d) Dilation: dilatation and curettage (diagnostic or therapeutic non-obstetrical); dilatation/probing of lacrimal duct.
(e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint
(f) Exam under anesthesia (pelvic).

g) Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
h) Extraction: foreign body, and teeth (per existing policy).
i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
j) Hymenotomy.
k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision.
m) Myringotomy with or without tubes, otoplasty.
n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
o) Removal: IUD, and fingernail or toenails.
p) Tenotomy hand or foot.
q) Vasectomy.
r) Z-plasty for relaxation of scar/contracture.

d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification

documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the service of physician assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Public Health free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any types(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act, including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services

Laboratory Services limited to a benefit schedule of covered laboratory procedures when ordered or prescribed by a duly-licensed physician or dentist.

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paragraph, existed; and such certification must also indicate the procedures used in providing such services. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

X-ray (radiological) services provided pursuant to 42 CFR 440.30 shall be limited to those procedures provided by a facility licensed to provide radiological services and which meets the requirements of 42 CFR 440.30 and other requirements as described herein.

(a) The facility shall participate in the Medicare Program;

(b) The procedure shall be ordered by a licensed physician, oral surgeon or dentist;

(c) The services shall be provided under the direction or supervision of a licensed physician;

(d) The facility shall not be a hospital outpatient department or clinic; and

(e) If the facility provides covered laboratory services, the facility must meet 42 CFR Part [redacted] (CLIA) requirements with regard to the laboratory services. (493 P&I HCFA 1/13/93)

4.a. Nursing Facility Services (Other Than Services in an Institution for Mental Diseases) for Individuals 21 Years of Age or Older

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, X-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

A. Dental Services

(1) Out-of-Hospital Care

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency and shown in provider manual.

Services not listed in the provider manual will be pre-authorized when medically necessary.

(1) Hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

B. Hearing Services

Audiological Benefits

(a) Coverage is limited to the following services provided by certified audiologists:

1) Complete hearing evaluation;
2) Hearing aid evaluation;
3) A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid, such visits to be related to the proper fit and adjustment of that hearing aid; and
4) One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.

(b) Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

Coverage is provided on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses are provided only to children under age 21. Coverage for eyeglasses is limited to two (2) pairs of eyeglasses per year per person.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

4.b EPSDT Services (continued)

D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services; a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required.

Neonatal Related Diagnoses

(1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
(2) Fetus or newborn affected by maternal complications of pregnancy.
(3) Fetus or newborn affected by complications of placenta, cord, and membranes.
(4) Fetus or newborn affected by other complications of labor and delivery.
(5) Slow fetal growth and fetal malnutrition.
(6) Disorders relating to short gestation and unspecified low birthweight.
(7) Disorders relating to long gestation and high birthweight.
(8) Birth Trauma
(9) Intrauterine hypoxia and birth asphyxia.
(10) Respiratory distress syndrome.
(11) Other respiratory conditions of fetus and newborn.
(12) Infections specific to the perinatal period.
(13) Fetal and neonatal hemorrhage.
(14) Hemolytic disease of fetus or newborn, due to isoimmunization.
(15) Other perinatal jaundice.
(16) Endocrine and metabolic disturbances specific to the fetus and newborn.
(17) Hematological disorders of fetus and newborn.
(18) Perinatal disorders of digestive system.
(19) Conditions involving the integument and temperature regulation of fetus and newborn
(20) Congenital anomalies and related surgical procedures.
(21) Other and ill-defined conditions originating in the perinatal period.

4.b. EPSDT Services (continued)

E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

5. Physicians' Services

A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

B. Coverage for established patient evaluation and management office or other outpatient services of moderate or high complexity is limited to one (1) per recipient, per physician, per diagnosis, per twelve (12) month period.

C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.

D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

E. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.

F. The cost of preparations used in injections is not considered a covered benefit, except for the following:

(1) The Rhogam injection.
(2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
(3) Depo Provera provided in the physician office setting.
(4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).

G. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.

H. Physician - patient telephone contacts are not covered.

I. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:

(1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.

(2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

J. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed.

K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

6. Medical care and any other type of Remedial Care

a. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

(1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.

(2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarressment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occulsive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:

  1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious amenia;
  2. *Associated with carcinoma;
  3. *Associated with diabetes mellitus;
  4. *Associated with drugs and toxins;
  5. *Associated with multiple sclerosis;
  6. *Associated with uremia (chronic renal disease);
  7. Associated with traumatic injury;
  8. Associated with leprosy or neurosyphilis; and
  9. Associated with hereditary disorders, such as: hereditary sensory radicular; neuropathy, angiokeratoma corposis; and diffusum (Fabry's), amyloid neuropathy.

Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

(3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscillometry.

Venous occulusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

(6) Medical care and Any Other Type of Remedial Care

(b) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also applicable:

1) Provision of eyeglasses is limited to recipients under age twenty-one (21).
2) Contact lenses are not covered.
3) Telephone contacts are not covered.
4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
5) If medically necessary, prisms shall be added within the cost of the lenses.

(c) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Registered Nurse Practitioner (ARNP) Services

(1) An ARNP covered service shall be a medically necessary service provided within the legal scope of practice of the ARNP and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.

(2) ARNP's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.

(3) An ARNP desiring to participate in the Medical Assistance Program shall:

(a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP;
(b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
(c) Accompany each participation application with a current copy of the ARNP's license; and
(d) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.

(4) Administration of anesthesia by an ARNP is a covered service.

(5) The cost of the following injectables administered by an ARNP in a physician or other independent practitioner's office shall be covered:
a. Rho (D) immune globulin injection;
b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
c. Depo-Provera contraceptive injection;
d. Penicillin G and ceftriaxone injectable antibiotics; and
e. Epidural injections administered for pain control.

(6) An outpatient laboratory procedure by an ARNP who has been certified in accordance with 42 CFR, Part 493 shall be covered.

Other Licensed Practitioners' Services (continued)

(d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable:

(1) Telephone contacts are not covered;

(2) Contact lens are not covered;

(3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, physician assistant or advanced registered nurse practitioner, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place of residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Homehealth Aide Services

Homehealth aide services must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies, Equipment, Prosthetics, and Orthotics Suitable for Use in the Home

Each Provider desiring to participate as a durable medical equipment, prosthetic, orthotic, or medical supply provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

Durable medical equipment, prosthetics, orthotics, and medical supplies are covered only in accordance with the following conditions:

1. The Department covers items specified in the Medicare region C DMERC DMEPOS Suppliers Manual. The provider may, however, submit requests for other specific items not covered by Medicare or not routinely covered by the Medicaid Program for consideration.

The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity. Unless specifically exempted by the Department, DME items, supplies, prosthetics, and orthotics will require a CMN completed by the prescriber that will be used by the department to document medical necessity.

2. Coverage of durable medical equipment and supplies, prosthetics, and orthotics for use of patients in the home is based on medical necessity and the requirements of 42 CFR 440.230(c).

   Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. Any equipment, prosthetic, orthotic, or supply billed (either purchased or repaired) at $300 or more must be prior authorized by the Department.

4. The criteria used in the determination of medical necessity includes an assessment of whether the item is:
   a. Provided in accordance with 42 CFR 440.230;
   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition;
   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;
   e. Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and,

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B, for recipients under twenty-one (21) years of age.

5. An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to stand repeated use. Coverage of an item of durable medical equipment, prosthetic, orthotic, or medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

6. The following general types of durable medical equipment, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:

a. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
b. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
c. Physical fitness equipment, such as exercycles and treadmills; and,
d. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, or speech pathology services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Audiology services are not provided under this component. Physical therapy, occupational therapy, or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Out-patient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

5a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and

2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

13. Dental Services

A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency and is shown in the provider manual.

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

B. Out-of Hospital Dental Services

A listing of dental services available to Medicaid recipient is maintained at the central office of the single state agency and is shown in the provider manual.

C. In-Hospital Care

Reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental or behavioral condition.

D. Oral Surgery

A listing of oral surgeon services available to Medicaid recipients is maintained at the central office of the single state agency and is shown in the provider manual.

11. Physical Therapy and Related Services

A. Physical Therapy (Limitations apply to both categories)

Coverage is limited to the provision of such services when (1) provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities as part of an approved plan of treatment or (2) when provided through participating home health agencies or hospital outpatient departments.

B. Occupational Therapy (Limitations apply to both categories)

Coverage is limited to the provision of such services through a participating home health agency, or when provided to patients in Skilled Nursing or Intermediate Care Facilities as part of an approved plan of treatment.

C. Services for Individuals with Speech, Hearing and Language Disorders-Provided by or under supervision of a speech pathologist or audiologi (Limitations apply to both categories.)

(1) Speech Disorders

Coverage is limited to the provision of such services when (1) provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities or (2) when provided through participating home health agencies or in hospital outpatient departments.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

a. Prescribed Drugs

(1) Coverage is provided for drugs included in the Outpatient Drug List that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs that require prior authorization are specified in the Outpatient Drug List. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.

(2) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Outpatient Drug List or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:

- A drug for which the FDA has issued a "less than effective (LTE)" rating or a drug "identical, related, or similar" to an LTE drug;
- A drug that has reached the termination date established by the drug manufacturer;
- A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug; and,

- A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program.

(3) A patient "locked-in" to one pharmacy due to over-utilization may receive pharmacy services only from his/her lock-in provider except in the case of an emergency or by referral.

(4) Prior authorization is required on covered prescriptions refilled up to 5 (five) times in a 6 (six) month period from the date of issue.

b. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the early, periodic, screening, diagnosis and treatment program (EPSDT).

c. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 7.3.1(a).

d. Eyeglasses

Eyeglasses are not covered for adults. Eyeglasses are covered for children through the vision program.

. Other diagnostic, screening, preventive and rehabilitative services, ie. other than those provided elsewhere in this plan.

a, b, c, and d. Such services are covered only when provided by mental health centers, primary care centers, and other qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

14.b. Nursing Facility Services for Individuals Age 65 or Older in
and Institutions for Mental Diseases.

c.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

Services in an Intermediate Care Facility for the Mentally Retarde

15.a. ~~Nursing Facility Services~~ (Other Than Such Services In an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a)(31)(A) of The Act, to be in Need of Such Care

Program benefits are limited to eligible recipients who require intermittent nursing facility care, continuous personal care and/or supervision. These services must be preauthorized and must be reevaluated every six months. If the reevaluation of care reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

~~b.~~ Including Such Services in a Public Institution (Or Distinct Part Thereof) For the Mentally Retarded or Persons with Related Conditions.

Program benefits are limited to those recipients who require intermittent nursing facility care, continuous personal care and/or supervision and/or who require care which is being provided in accordance with an established plan developed as a result of a comprehensive medical, social, and psychological evaluation. These services must be preauthorized and must be reevaluated every six months thereafter. If the reevaluation of care reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program for 15.a. and 15.b. above when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges: the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, X-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

The following limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

(1) Program benefits are limited to eligible recipients who require inpatient psychiatric facility services on a continuous basis as a result of a severe mental or psychiatric illness (including severe emotional disturbances) as shown in ICD-9-CM~~ (except as further excluded in item 3, below)~~. Services shall not be covered if appropriate alternative services are available in the community. Services must be preauthorized and reevaluated at thirty day intervals. 9.11.91 (PoI-HCFA)

(2) Services may be provided in a psychiatric hospital; or in a licensed psychiatric residential treatment facility which meets the requirements of 42 CFR 441 Subpart D.

20.b. Rehabilitative Services for Pregnant Woman

The following substance abuse services are covered for pregnant and postpartum women for a sixty-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls for treatment of a substance related disorder, excluding nicotine dependence.

(1) Substance abuse assessment. An assessment is to include the presenting problem, substance abuse diagnosis (if identified) and the development of an initial plan of care.

(2) Prevention Services. The prevention services are designed to reduce the risk that an individual will initiate or continue using alcohol, tobacco, and other drugs during pregnancy and the postpartum period. Services will be delivered through approved protocols that may include pre-test and post test surveys, videos with discussion guides, motivational interviewing, participant workbooks, and supportive therapeutic interventions. Services are provided with a face-to-face contact between an individual and a qualified provider, on an outpatient basis and may be delivered in an individual or group setting. Individuals are provided the following services based upon their needs:

(a) Universal prevention service.

1. Targeted audience: Includes members of the population that exhibits no characteristics or behaviors that place them at greater risk of developing alcohol or drug problems or substance dependence.
2. Goals and objectives:
   a. Continued or increased perceptions of potential harm to the fetus as a result of using alcohol, tobacco or other drugs during pregnancy;
   b. Continued or increased intentions to not use alcohol, tobacco and other drugs during pregnancy and lactation; and
   c. Increased ability to recognize signs of postpartum depression and risk for substance abuse following pregnancy.
3. Service limitation: A substance abuse universal prevention service shall be provided in ¼ hour increments, not to exceed a total of two (2) hours.

(b) Selective prevention service.

1. Targeted audience: Includes members of the population that have been identified as having a greater incidence of problems associated with their use and/or higher incidences of developing chemical dependence (i.e. Children of Alcoholics, survivors of sexual abuse or domestic violence).
2. Goals and objectives:
   a. Abstinence from alcohol, tobacco and other drugs during pregnancy and lactation;
   b. Increased commitment to not use during pregnancy and lactation;
   c. Continued or increased perceptions of potential harm to a fetus when alcohol, tobacco or other drugs are used;
   d. Increased awareness of personal vulnerability to alcohol or drug dependency or other problems throughout life;
   e. Attitude changes which support an individual in making low risk choices related to tobacco, alcohol and other drug use during and following pregnancy; and
   f. Developing skills necessary to make and maintain low risk alcohol and other drug choices throughout life.
3. Service limitation. A selective prevention service shall be provided in ¼ hour increments, not to exceed a total of nineteen (19) hours.

20.b. Rehabilitative Services for Pregnant Woman (continued)

(c) Indicated prevention service.

1. Targeted audience: Includes members of the population that do not have a diagnosis of substance abuse or dependency, but do report actually experiencing some problems related to their use of alcohol and drugs.
2. Goals and objectives:
   a. Decreased alcohol and other drug use;
   b. Attitude changes which support an individual in making low risk choices related to alcohol and other drug use;
   c. A greater readiness for and response to treatment for an individual with a substance abuse related diagnosis who is receiving this service as an adjunct to a substance abuse treatment plan; and
   d. Increased skills necessary to make and maintain low risk alcohol and other drug use choices during pregnancy and throughout life.
3. Service limitation. An indicated prevention service shall be provided in ¼ hour increments, not to exceed a total of twenty-seven (27) hours.

(d) Qualifications of providers. All of the prevention services are provided by a Kentucky certified preventionist or a Qualified Substance Abuse Treatment Professional (QSATP) with training in prevention strategies and procedures.

(3) Outpatient services.

(a) Outpatient services may include:

1. Individual therapy;
2. Group therapy;
3. Family therapy. This service is counseling provided to an eligible individual and one (1) or more significant others with the primary purpose of which is the treatment of the individual's condition;
4. Psychiatric evaluation provided by a psychiatrist;
5. Psychological testing provided by a psychologist;
6. Medication management provided by a physician or an advanced registered nurse practitioner; and
7. Collateral care. Involves counseling or consultation services provided directly or indirectly to the recipient through the involvement of a person or person's in a position of custodial control or supervision of the individual in the counseling process. Services are to meet the treatment needs of the eligible individual and shall be a part of the individual's treatment plan. Presence of the recipient in the counseling session is not necessarily required. However, when the recipient is present, reimbursement for the collateral counseling and individual or group counseling for the same session is not allowed.

(b) Service limitations.

1. Group therapy.
   a. There shall be no more than twelve (12) persons in a group therapy session; and
   b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.
2. Collateral care shall be limited to individuals under age twenty-one (21) and no more than four and one-half (4.5) hours of service shall be reimbursed during a one (1) month period.
3. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.

20.b. Rehabilitative Services for Pregnant Woman (continued)

(4) Day Rehabilitation Services.

(a) Shall be an array of substance abuse treatment services in a structured program format that is scheduled to take place multiple hours a day, several times a week and may include individual and group therapy, information on substance abuse and its effects on health, fetal development and interpersonal relationships.

(b) May be covered when provided to an individual in a non-residential setting or as a component of a residential program.

(c) Service limitations:

1. Reimbursement for a day rehabilitation service provided in a non-residential setting shall be limited to no more than 7 hours per day not to exceed twenty (20) hours per week.
2. Reimbursement for a day rehabilitation service provided in a residential setting shall be limited to no more than 8 hours per day not to exceed forty-five (45) hours per week.
3. Payment shall not be made for care or services for any individual who is a patient in an institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.
4. Room and board costs shall not be covered under this benefit.

(5) Outpatient and Day Rehabilitation services shall be provided by a qualified substance abuse treatment professional (QSATP) that meets one of the following requirements:

(a) A certified alcohol and drug counselor; or

(b) An individual who holds a license or certification in medicine, psychology, social work, nursing, marriage and family therapy, professional counselor, or art therapy with 24 hours of additional training in substance abuse or dependency related problems and information specific to working with the target population; or

(c) A bachelor's or greater degree with additional training of 45 hours with 12 hours in substance abuse or dependence related problems, 12 hours specific to the target population, 12 hours in prevention strategies and procedures, and the remaining 9 hours may be in one or more of the identified training topics.

(6) Community support services.

(a) A community support service shall be provided if the service is identified as a need in the individual's treatment plan.

(b) A community support service shall be a face-to-face or telephone contact between an individual and a qualified community support provider.

(c) A community support service shall include:

1. Assisting an individual in remaining engaged with substance abuse treatment or community self-help groups;
2. Assisting an individual in resolving a crisis in an individual's natural environment; and

20.b. Rehabilitative Services for Pregnant Woman (continued)

3. Coaching an individual in her natural environment to:
   a. Access services arranged by a case manager; and
   b. Apply substance abuse treatment gains, parent training and independent living skills to an individual's personal living situation.

(d) A community support provider shall coordinate the provision of community support services with an individual's primary provider of case management services.

(e) Community support staff qualifications.

1. A high school diploma or general equivalent diploma.
2. Two years of supervised experience in substance abuse treatment setting and knowledge of substance abuse related self-help groups.
3. Twenty hours of training on the dynamics and treatment of substance abuse, recovery issues unique to pregnant women and women with dependent children and HIV positive individuals, strategies to defuse resistance, professional boundary issues that address enabling behaviors and protecting a staff member, who may be a recovering substance abuser, from losing their own sobriety.

(7) Reimbursement for a substance abuse service shall not be payable for an individual who is a resident in a Medicaid-reimbursed inpatient facility.

(a) Reimbursement for services shall be based on the following units of service:

1. Universal prevention service shall be a one-quarter (1/4) hour unit;
2. Selective prevention service shall be a one-quarter (1/4) hour unit;
3. Indicated prevention service shall be a one-quarter (1/4) hour unit;
4. Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:
   a. Individual therapy;
   b. Group therapy;
   c. Family therapy;
   d. Psychiatric evaluation;
   e. Psychological testing;
   f. Medication management; and
   g. Collateral care.
5. An assessment service shall be a one-quarter (1/4) hour outpatient unit;
6. Day rehabilitation services shall be a one (1) hour unit;
7. Case management services shall be a one-quarter (1/4) hour unit; and
8. Community support shall be a one-quarter (1/4) hour unit.

(b) Qualifications of Providers

1. Services are covered only when provided by any mental health center, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations.
2. The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
3. A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.

State Kentucky

18. Hospice Limitation

The following hospice limitation is applicable: A Medicaid eligible individual who wishes to elect coverage under Medicaid for hospice care and who is eligible for hospice care under Medicare, must elect coverage under both programs for coverage to exist under Medicaid.

24. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.

A. Transportation

1. Ambulance Services.

(1) Emergency ambulance services shall be provided without preauthorization to and from the nearest hospital emergency room or appropriate medical facility or provider. A statement that the Medicaid recipient received emergency services shall be obtained from the medical personnel of the facility which treated the recipient.

(2) Nonemergency ambulance services to a hospital, clinic, physician's office or other health facility shall be provided if preauthorized. If the Department for Social Insurance local office is closed, the nonemergency ambulance service shall be postauthorized. Preauthorization and postauthorization shall be performed by the Department for Medicaid Services or its authorized representative utilizing criteria shown in Items 2. and 3.

2. Locally Authorized Medical Transportation.

(1) A transportation preauthorization system administered at each local Department for Social Insurance Office shall provide for preauthorized nonemergency transportation approvals, including nonemergency ambulance services, limited to the provision of the services under the following conditions:

(a) the recipient shall be traveling to or from a Medicaid covered service under the state plan, exclusive of pharmaceutical services;

(b) the service shall be determined to be medically necessary;

(c) payment for transportation shall be necessary to ensure that the medical service is secured;

(d) failure to pay for transportation results in a hardship to the Medicaid recipient. A hardship shall not be considered to exist if free transportation which is appropriate for the recipient's medical needs is available or if use of an operational household vehicle is available, appropriate, and is not used for commercial purposes; and

(e) the medical transportation provider, including a private automobile carrier, has a signed participation agreement with the Department for Medicaid Services.

(2) Locally authorized medical transportation shall be provided as necessary on an exceptional postauthorization basis with the additional limitation that the postauthorization shall be justified by the recipient indicating the need for medical transportation arose and was provided outside normal working hours and that payment for the transportation has not been made.

3. Determination of Necessity.

(1) All approvals for nonemergency transportation services and the provision of preauthorization and postauthorization, shall be made by the Department for Medicaid Services or by the Department's authorized representative.

(2) Only transportation within the medical service area shall be approved. Transportation services provided outside the medical service area shall be approved by the Department for Medicaid Services or the Department's authorized representative if the medical service required by the recipient is not available in that area and the recipient has been appropriately referred by a local medical provider.

(3) Only the least expensive available transportation suitable for the recipient's needs shall be approved.

23.d. Nursing Facility Services for Patients Under 21 Years of Age

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

/X/ Provided: /X/ With limitations

/ / Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

/X/ Provided: + / / Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

/X/ Provided: + /X/ Additional coverage ++

/ / Not provided.

c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a)(10)(A)(ii)(IX) of the Act.

/X/ Provided: + /X/ Additional coverage ++

/ / Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/X/ Provided: /X/ No limitations /_/ With limitations*

/_/ Not provided.

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

23. Certified pediatric or family nurse practitioners' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

See item 6d for limitations.

* Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

c. Reserved

d. Nursing facilities for patients under 21 years of age.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

e. Emergency hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

* Description provided on attachment

State: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

_X_ provided

___ not provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is involved to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(continued on next page)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate.

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
   (a) assessment
   (b) care/services plan development
   (c) linking/coordination of services
   (d) reassessment/followup
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

(Continued on next Page)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.

2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for Severely Emotionally Disturbed Children

A. Target Groups: By involving the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Age 0-21 and meet the state's conditions and circumstances to be defined as a "severely emotionally disturbed child."

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provide services less than statewide:

C. Comparability of Services

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 (a) (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(1) A written comprehensive assessment of the child's needs;
(2) Arranging for the delivery of the needed services as identified in the assessment;
(3) Assisting the child and his family in accessing needed services;
(4) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing needs;
(5) Performing advocacy activities on behalf of the child and his family;
(6) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
(7) Providing case consultation (i.e., consulting with the service providers/collateral's in determining child's status and progress); and
(8) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Provider participation shall be limited to the Kentucky Department for Social Services and the fourteen Regional Mental Health Mental Retardation Centers, licensed in accordance with state regulations.

Qualifications of Case Manager and Supervision Requirement

(1) Case Manager Qualifications. Each case manager shall be required to meet the following minimum requirements:

(a) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the behavioral sciences from an accredited institution; and

(b) Have one (1) year of experience working directly with children or performing case management services (except that a master's degree in a human services field may be substituted for the one (1) year of experience); and

(c) Have received training within six (6) months designed and provided by each participating provider directed toward the provision of case management services to the targeted population; and

(d) Have supervision for a minimum of one (1) year by a mental health professional; i.e., psychiatrist, psychologist, master's level social worker (MSW), psychiatric nurse or professional equivalent (a minimum of a bachelor's degree in a human services field, with two (2) years of experience in mental health related children's services). The supervisor shall also complete the required case management or training course.

(2) Case Manager Supervision Requirement. For at least one (1) year, each case manager shall have supervision performed at least once a month for each case plan.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the providers of case management services.

(2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purposes.

State Kentucky

Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and

2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.

B. Areas of State in which services will be provided:

_X_ Entire State.

____ Only in the following geographic areas (authority of Section 1915(g)(1) of the act is invoked to provide services less than statewide):

C. Comparability of Services

___ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(l) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(1) A written assessment of the child or adult's needs;

(2) Arranging for the delivery of the needed services as identified in the assessment;

(3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult.

(4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;

(5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs.

(6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc following provision of service to the child or the adult on behalf of the child or adult.

(7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and

(8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

(1) Demonstrated capacity to provide all core elements of case management including

(a) assessment;
(b) care/services plan development;
(c) linking/coordination of services; and
(d) reassessment/follow-up.

(2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations.

(3) Demonstrated experience with one of the target populations.

(4) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(5) Have a financial management system that provides documentation of services and costs.

(6) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(7) Demonstrated ability to assure a referral process consistent with Section 1902(a)(23) of the Act, freedom of choice of provider.

(8) Demonstrated capacity to meet the case management service needs of the target population.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

(1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
(2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the providers of case management services.
(2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 Participating in the Kentucky Early Intervention Program

A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

X Entire State

__ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:

C. Comparability of Services

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with on-going service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

(1) Assessment of child's medical, social and functional status and identification of service needs;
(2) Initial service coordination from notice of referral through initial IFSP development;
(3) Assuring that all procedural safeguards are met during intake and IFSP development;
(4) Arranging for and coordinating the development of the child's IFSP;
(5) Arranging for the delivery of the needed services as identified in the IFSP;
(6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
(7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
(8) Performing activities to enable an eligible individual to gain access to needed services;
(9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
(10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

(11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and

(12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915(g)(1) of the Social Security Act, qualified providers shall be the Title V agency, the Department for Mental Health and Mental Retardation Services, and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:

a) assessment;

b) care/services plan development;

c) linking/coordination of services; and

d) reassessment/follow-up.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;

3. Demonstrated experience with the target population;

4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and

5. A financial management system that provides documentation of services and costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

A. Have a Bachelor's degree; and
(1) 2 years experience in service coordination for children with disabilities up to age 18; or
(2) 2 years experience in service provision to children under six years of age; or

B. Meet one of the following professional criteria:

1. Audiologist - Licensed or Certified,
2. Family Therapist - M.A. and Certified,
3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
4. Developmental Associate,
5. Registered Nurse,
6. Advanced Registered Nurse Practitioner,
7. Dietitian - Licensed,
8. Occupational Therapist - Licensed,
9. Occupational Therapist Assistant - B.S. and Licensed,
10. Orientation and Mobility Specialist - Certified,
11. Physical Therapist - Licensed,
12. Psychologist - Licensed or Certified,
13. Speech Language Pathologist - Licensed or Certified,
14. Speech Language Assistance - Licensed,
15. Social worker - Licensed,
16. Physician, Licensed,
17. Nutritionist, Licensed

F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the available providers of case management services.

(2) Eligible recipients will have free choice of the available providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Pregnant women who have not reached their twentieth birthday and will be first time teen parents;
2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program which shall be called Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed; inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.

B. Areas of State in which services will be provided:

X Entire State

_ Only in the following geographic areas (authority of Section 1915(g)(1)of the Act is involved to provided services less that state wide:

C. Comparability of Services:

_ Services are provided in accordance with 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).

D. Definition of Services

Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirement of Section 1902(a)(23) of the Act, the providers will monitor client treatment to

assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment

   a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;

   b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:

      1) parent's childhood experience;

      2) lifestyle behaviors and mental health status;

      3) parenting experience;

      4) stressors, coping skills and support system for the new family;

      5) anger management skills;

      6) expectations of infant's developmental milestones and behaviors;

      7) perception of new infant, and bonding and attachment issues;

      8) plans for discipline; and

      9) family environment and support system.

   c) Develops a written report of the findings and a service plan for the family.

   d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

2. Home Visitation

a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker or early childhood development specialist may perform a home visit;

b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;

b) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;

c) Perform activities to enable the child and family to gain access to needed services;

d) Prepare and maintain case records documenting contacts, services needed, reports, progress;

e) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and

f) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

1. Providers must be certified as a Medicaid provider meeting the following criteria:

a) Demonstrated capacity to contract statewide for the case management services for the targeted population;

b) Demonstrated capacity to ensure all components of case management including;
   1) screening,
   2) assessment,
   3) treatment plan development,
   4) home visiting,
   5) linking/coordination of services, and
   6) follow-up and evaluation;

c) Demonstrated experience in coordinating and linking such community resources as required by the target population;

d) Demonstrated experience with the target population;

e) Administrative capacity to insure quality of services in accordance with state and federal requirements;

f) Demonstrated capacity to provide certified training and technical assistance to case managers;

g) Financial management system that provides documentation of services and costs;

h) Capacity to document and maintain individual case records in accordance with state and federal requirements;

i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and

j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

a) Registered Nurse – Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.

b) Social Worker – Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.

c) Early Childhood Development Specialist – have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.

d) Family Support Worker (FSW) – Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, HIV/AIDS training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the available providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

PACE SERVICES

X The State of Kentucky has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

____ The State of _____ has entered into a valid program agreement(s) with a PACE provider(s) and the secretary, as follows:

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: _____

This information should be provided for all PACE providers with which the State Administering Agency for PACE and the Secretary have entered into valid program agreements.)

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided:

Physician's Services
Rural Health Clinic
Outpatient Hospital
Laboratory and X-Ray
EPSDT
Physical Therapy
Dental
Hearing
Vision
Home Health
Clinic
Emergency Hospital
Transportation
Nurse-midwife Services
Hospice Care
Case Management
Federally Qualified Health Center Services

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/x/Provided: /_/No limitations /x/With limitations*

2.a. Outpatient hospital services.

/x/Provided: /_/No limitations /x/With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan).

/x/Provided: /_/No limitations /x/With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/x/ Provided /_/ No limitations /x/ With limitations*

3. Other laboratory and X-ray services.

/x/ Provided: /_/ No limitations /x/With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/x/Provided: /_/No limitations /x/With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

/x/Provided:

c. Family planning services and supplies for individuals of childbearing age.

/x/Provided: /_/No limitations /x/With limitations*

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(s): All

5. a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___No limitations _X_ With limitations:

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as define by State law.

   a. Podiatrists' Services

   /X/ Provided: /__/ No limitations /X/ With limitations*

   b. Optometrist' Services

   /X/ Provided: /__/ No limitations /X/ With limitations*

   c. Chiropractors' Services

   /X/ Provided: /X/ No limitations /__/ With limitations*

   d. Other Practitioners' Services

   /X/ Provided: /__/ No limitations /X/ With limitations*

7. Home Health Services

   a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

   /X/ Provided: /__/ No limitations /X/ With limitations*

   b. Home health aide services provided by a home health agency.

   /X/ Provided: /__/ No limitations /X/ With limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

   /X/ Provided: /__/ No limitations /X/ With limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audology services provided by a home health agency or medical rehabilitation facility.

   /X/ Provided: /__/ No limitations /X/ With limitations*

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED MEDICALLY NEEDY GROUP(S): ALL

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Preventive services.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Nursing facility services.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description of limitations provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

c. Intermediate care facility services.

[X] Provided: [ ] No limitations [X] With limitations*

Services in an Intermediate Care Facility for the Mentally Retarded

15. a. ~~Nursing facility services~~ (other than such services in an institution for mental disease) for persons determined in accordance with section 1902(a)(31)(1) of the Act, to be in need of such care.

[X] Provided: [ ] No limitations [X] With limitations*

~~b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.~~

~~[X] Provided: [ ] No limitations [X] With limitations*~~

16. Inpatient psychiatric facility services for individuals under 22 years of age.

10/1/90 [X] Provided: [ ] No limitations [X] With limitations*

17. Nurse-midwife services.

[X] Provided: [X] No limitations [ ] With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations [ ] Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after pregnancy ends and for any remaining days in the month in which the 60th day falls.

[X] Provided: + [ ] Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

[X] Provided: + [X] Additional coverage ++ [ ] Not provided.

21. Certified pediatric or family nurse practitioners' services

PIT HCFA 11-14-94

[X] Provided: [ ] No limitations [X] With limitations*

See item 6d for limitations

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medic condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.)

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

c. Reserved

d. Nursing facilities for patients under 21 years of age.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

e. Emergency hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

* Description provided on attachment

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S):

25. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

_X_ Provided _X_ No limitations ___ With limitations

___ Not provided

26. Program of All-inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

_X_ Provided ___ Not provided

1. Inpatient Hospital Services

a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program; this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing

b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:

(a) Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
(b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
(c) Circumcision.
(d) Dilation: dilation and curettage (diagnostic and or therapeutic non-obstetrical); dilation/probing of lacrimal duct.
(e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint.
(f) Exam under anesthesia (pelvic).
(g) Excision: bartholing cyst, cyndylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
(h) Extraction: foreign body, and teeth (per existing policy).
(i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
(j) Hymenotomy.
(k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
(l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision.
(m) Myringotomy with or without tubes, otoplasty.
(n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, gastroscopy, hysteroscopy, laryngoscopy, peritoneoscopy, otoscopy, and sigmoidoscopy or procto sidmoidoscopy.
(o) Removal: IUD, and fingernail or toenails.
(p) Tenotomy hand or foot.
(q) Vasectomy.
(r) Z-plasty for relaxation of scar/contracture.

d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed; and such certification must also indicate the procedures used in providing such services. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

Hospital outpatient services are limited to therapeutic and diagnostic service as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed; and such certification must also indicate the procedures used in providing such services. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-B pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the services of physician assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Health Services free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act, including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services

Laboratory Services limited to a benefit schedule of covered laboratory procedures when ordered or prescribed by a duly-licensed physician or dentist.

X-ray (radiological) services provided pursuant to 42 CFR 440.30 shall be limited to those procedures provided by a facility licensed to provide radiological services and which meets the requirements of 42 CFR 440.30 and other requirements as described herein.

a) The facility shall participate in the Medicare Program;

b) The procedure shall be ordered by a licensed physician, oral surgeon or dentist;

c) The services shall be provided under the direction or supervision of a licensed physician;

d) The facility shall not be a hospital outpatient department or clinic; and

e) If the facility provides covered laboratory services, the facility must meet 42 CFR Part 493 (CLIA) requirements with regard to the laboratory services.

4.a. Nursing Facility Services (Other Than Services in an Institution for Mental Disease) for Individuals 21 Years of Age or Older and Treatment of Conditions Found

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges, the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

A. Dental Services

(1) Out-of-Hospital Care

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency and shown in provider manual.

Services not listed in the provider manual will be pre-authorized when medically necessary.

(2) Hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

B. Hearing Services

Audiological Benefits

(a) Coverage is limited to the following services provided by certified audiologists:

1) Complete hearing evaluation;
2) Hearing aid evaluation;
3) A maximum of three follow-up visits within the six-month period immediately following fitting of a hearing aid, such visits to be related to the proper fit and adjustment of that hearing aid;
4) One follow-up visit six months following fitting of a hearing aid, to assure patient's successful use of the aid.

Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

(b) Exception to the above limitations may be made through pre-authorization if medical necessity is indicated in the individual case.

(2) Hearing Aid Benefits

Coverage is provided on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a Medicaid participating hearing aid dealer.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses are provided only to children under age 21. Coverage for eyeglasses is limited to two (2) pairs of eyeglasses per year per person.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

4.b EPSDT Services (continued)

D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services; a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required.

Neonatal Related Diagnoses

(1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
(2) Fetus or newborn affected by maternal complications of pregnancy.
(3) Fetus or newborn affected by complications of placenta, cord, and membranes.
(4) Fetus or newborn affected by other complications of labor and delivery.
(5) Slow fetal growth and fetal malnutrition.
(6) Disorders relating to short gestation and unspecified low birthweight.
(7) Disorders relating to long gestation and high birthweight.
(8) Birth Trauma
(9) Intrauterine hypoxia and birth asphyxia.
(10) Respiratory distress syndrome.
(11) Other respiratory conditions of fetus and newborn.
(12) Infections specific to the perinatal period.
(13) Fetal and neonatal hemorrhage.
(14) Hemolytic disease of fetus or newborn, due to isoimmunization.
(15) Other perinatal jaundice.
(16) Endocrine and metabolic disturbances specific to the fetus and newborn.
(17) Hematological disorders of fetus and newborn.
(18) Perinatal disorders of digestive system.
(19) Conditions involving the integument and temperature regulation of fetus and newborn
(20) Congenital anomalies and related surgical procedures.
(21) Other and ill-defined conditions originating in the perinatal period.

4.b. EPSDT Services (continued)

E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

5. Physicians' Services

A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

B. Coverage for established patient evaluation and management office or other outpatient services of moderate or high complexity is limited to one (1) per recipient, per physician, per diagnosis, per twelve (12) month period.

C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.

D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

E. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.

F. The cost of preparations used in injections is not considered a covered benefit, except for the following:

(1) The Rhogam injection.
(2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
(3) Depo Provera provided in the physician office setting.
(4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).

G. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.

H. Physician - patient telephone contacts are not covered.

I. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:

(1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.

(2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

6. Medical Care and Any Other Type of Remedial Care

a. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

(1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.

(2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

J. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed.

K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarressment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occulsive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:

  1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious amenia;
  2. *Associated with carcinoma;
  3. *Associated with diabetes mellitus;
  4. *Associated with drugs and toxins;
  5. *Associated with multiple sclerosis;
  6. *Associated with uremia (chronic renal disease);
  7. Associated with traumatic injury;
  8. Associated with leprosy or neurosyphilis; and
  9. Associated with hereditary disorders, such as: hereditary sensory radicular; neuropathy, angiokeratoma corposis; and diffusum (Fabry's), amyloid neuropathy.

Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

(3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscillometry.

Venous occulusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

(6) Medical care and Any Other Type of Remedial Care

(a) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also applicable:

1) Provision of eyeglasses is limited to recipients under the age of twenty-one (21).
2) Telephone contacts are not covered.
3) Contact lens are not covered;
4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

(b) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Registered Nurse Practitioner (ARNP) Services

(1) An ARNP covered service shall be a medically necessary service provided within the legal scope of practice of the ARNP and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.

(2) ARNP's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.

(3) An ARNP desiring to participate in the Medical Assistance Program shall:
- (a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP;
- (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
- (c) Accompany each participation application with a current copy of the ARNP's license; and
- (d) Provide and bill for services in accordance with the terms and conditions of the provider participation agreement.

(4) Administration of anesthesia by an ARNP is a covered service.

(5) The cost of the following injectables administered by an ARNP in a physician or other independent practitioner's office shall be covered:
- a. Rho (D) immune globulin injection;
- b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
- c. Depo-Provera contraceptive injection;
- d. Penicillin G and ceftriaxone injectable antibiotics; and
- e. Epidural injections administered for pain control.

(6) An outpatient laboratory procedure by an ARNP who has been certified in accordance with 42 CFR, Part 493 shall be covered.

(7) An obstetrical and gynecological service provided by an ARNP shall be covered as follows:

a. An annual gynecological examination;
b. An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
c. The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
d. Prenatal care;
e. A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
f. A delivery service, which shall include:
    1. Admission to the hospital;
    2. Admission history;
    3. Physical examination,
    4. Anesthesia;
    5. Management of uncomplicated labor;
    6. Vaginal delivery; and
    7. Postpartum care.

(8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.

(9) A limitation on a service provided by a physician as described in Attachment 3.1-B, pages 21, 22 and 22.1(a) shall also apply if the service is provided by an ARNP.

(10) The same service provided by an ARNP and a physician on the same day within a common practice shall be considered as one (1) covered service.

Other Licensed Practitioners' Services (continued)

(d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable.

(1) Telephone contacts are not covered;

(2) Contact lens are not covered;

(3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, physician assistant or advanced registered nurse practitioner, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place of residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Homehealth Aide Services

Homehealth aide services must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies, Equipment, Prosthetics, and Orthotics Suitable for Use in the Home

Each Provider desiring to participate as a durable medical equipment, prosthetic, orthotic, or medical supply provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

Durable medical equipment, prosthetics, orthotics, and medical supplies are covered only in accordance with the following conditions:

1. The Department covers items specified in the Medicare region C DMERC DMEPOS Suppliers Manual. The provider may, however, submit requests for other specific items not covered by Medicare or not routinely covered by the Medicaid Program for consideration.

The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity. Unless specifically exempted by the Department, DME items, supplies, prosthetics, and orthotics will require a CMN completed by the prescriber that will be used by the department to document medical necessity.

2. Coverage of durable medical equipment and supplies, prosthetics, and orthotics for use of patients in the home is based on medical necessity and the requirements of 42 CFR 440.230(c).

   Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. Any equipment, prosthetic, orthotic, or supply billed at $300.00 or more must be prior authorized by the Department.

4. The criteria used in the determination of medical necessity includes an assessment of whether the item is:

   a. Provided in accordance with 42 CFR 440.230;
   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition.
   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider.
   e. Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and,
   g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B, for recipients under twenty-one (21) years of age.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to stand repeated use. Coverage of an item of durable medical equipment, prosthetic, orthotic, or medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

6. The following general types of durable medical equipment, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:

   a. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
   b. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
   c. Physical fitness equipment, such as exercycles and treadmills; and,
   d. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, or speech pathology services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Audiology services are not provided under this component. Physical therapy, occupational therapy, or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Outpatient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

5a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and

2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

10. Dental Services

A. A listing of dental services available to recipients age 21 and over is also maintained at the central office of the single state agency and is shown in the provider manual.

B. Out-of-Hospital Care

A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency and is shown in the provider manual.

C. In-Hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be [provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental or behavioral condition.

D. Oral Surgeon Services

A listing of oral surgeon services available to Medicaid recipients is maintained at the central office of the single state agency and is shown in the provider manual.

11. Physical Therapy and Related Services

a. Physical Therapy (Limitations apply to both categories)

Coverage is limited to the provision of such services when (1) provided to inpatients of acute participating hospitals and nursing facilities as part of an approved plan of treatment or (2) when provided through participating home health agencies or hospital outpatient departments.

b. Occupational Therapy (Limitations apply to both categories)

Coverage is limited to the provision of such services through a participating home health agency, or when provided to patients in nursing facilities as part of an approved plan of treatment.

c. Services of Individuals with Speech, Hearing and Language Disorders--Provided by or under supervision of a speech pathologist or audiologist (Limitations apply to both categories)

(1) Speech Disorders

Coverage is limited to the provision of such services when (1) provided to inpatients of acute participating hospitals and nursing facilities or (2) when provided through participating home health agencies or in hospital outpatient departments.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

a. Prescribed Drugs

(1) Coverage is provided for drugs included in the Outpatient Drug List that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs that require prior authorization are specified in the Outpatient Drug List. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.

(2) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Outpatient Drug List or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:

- A drug for which the FDA has issued a "less than effective (LTE)" rating or a drug "identical, related, or similar" to an LTE drug;
- A drug that has reached the termination date established by the drug manufacturer;
- A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug; and,

- A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program.

(3) A patient "locked-in" to one pharmacy due to over-utilization may receive pharmacy services only from his/her lock-in provider except in the case of an emergency or by referral.

(4) Prior authorization is required on covered prescriptions refilled up to 5 (five) times in a 6 (six) month period from the date of issue.

b. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the early, periodic, screening, diagnosis and treatment program (EPSDT).

c. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 7.3.1(a).

d. Eyeglasses

Eyeglasses are not covered for adults. Eyeglasses are covered for children through the vision program.

13. Other diagnostic, screening, preventive and rehabilitative services, ie. other than those provided elsewhere in this plan.

a, b, c, and d. Such services are covered only when provided by mental health centers, primary care centers, and other qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

14.b. and c. Nursing Facility Services for Individuals Age 65 or Older in Institutions for Mental Diseases.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

15.a. Services in an Intermediate Care Facility for the Mentally Retarded ~~Nursing Facility Services~~ (Other Than Such Services In an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a)(31)(A) of The Act, to be in Need of Such Care

Program benefits are limited to eligible recipients who require intermittent nursing facility care, continuous personal care and/or supervision. These services must be preauthorized and must be reevaluated every six months thereafter. If the reevaluation of care reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

~~b.~~ Including Such Services in a Public Institution (Or Distinct Part Thereof) For the Mentally Retarded or Persons with Related Conditions.

Program benefits are limited to those recipients who require intermittent nursing facility care, continuous personal care and/or supervision and/or who require care which is being provided in accordance with an established plan developed as a result of a comprehensive medical, social, and psychological evaluation. These services must be preauthorized and must be reevaluated every six months thereafter. If the reevaluation of care reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program for 15.a. and 15.b. above when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, X-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

The following limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

(1) Program benefits are limited to eligible recipients who require inpatient psychiatric facility services on a continuous basis as a result of a severe mental or psychiatric illness (including severe emotional disturbances) as shown in ICD-9-CM. ~~(except as further excluded in item 3, below).~~ Services shall not be covered if appropriate alternative services are available in the community. Services must be preauthorized and reevaluated at thirty day intervals. 9-11-91 (P.I. HCFA)

(2) Services may be provided in a psychiatric hospital; or in a licensed psychiatric residential treatment facility which meets the requirements of 42 CFR 441 Subpart D.

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18. Hospice Limitation

The following hospice limitation is applicable: A Medicaid eligible individual who wishes to elect coverage under Medicaid for hospice care and who is eligible for hospice care under Medicare, must elect coverage under both programs for coverage to exist under Medicaid.

20.b. Rehabilitative Services for Pregnant Woman

The following substance abuse services are covered for pregnant and postpartum women for a sixty-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls for treatment of a substance related disorder, excluding nicotine dependence.

(1) Substance abuse assessment. An assessment is to include the presenting problem, substance abuse diagnosis (if identified) and the development of an initial plan of care.

(2) Prevention Services. The prevention services are designed to reduce the risk that an individual will initiate or continue using alcohol, tobacco, and other drugs during pregnancy and the postpartum period. Services will be delivered through approved protocols that may include pre-test and post test surveys, videos with discussion guides, motivational interviewing, participant workbooks, and supportive therapeutic interventions. Services are provided with a face-to-face contact between an individual and a qualified provider, on an outpatient basis and may be delivered in an individual or group setting. Individuals are provided the following services based upon their needs:

(a) Universal prevention service.

1. Targeted audience: Includes members of the population that exhibits no characteristics or behaviors that place them at greater risk of developing alcohol or drug problems or substance dependence.
2. Goals and objectives:
   a. Continued or increased perceptions of potential harm to the fetus as a result of using alcohol, tobacco or other drugs during pregnancy;
   b. Continued or increased intentions to not use alcohol, tobacco and other drugs during pregnancy and lactation; and
   c. Increased ability to recognize signs of postpartum depression and risk for substance abuse following pregnancy.
3. Service limitation: A substance abuse universal prevention service shall be provided in ¼ hour increments, not to exceed a total of two (2) hours.

(b) Selective prevention service.

1. Targeted audience: Includes members of the population that have been identified as having a greater incidence of problems associated with their use and/or higher incidences of developing chemical dependence (i.e. Children of Alcoholics, survivors of sexual abuse or domestic violence).
2. Goals and objectives:
   a. Abstinence from alcohol, tobacco and other drugs during pregnancy and lactation;
   b. Increased commitment to not use during pregnancy and lactation;
   c. Continued or increased perceptions of potential harm to a fetus when alcohol, tobacco or other drugs are used;
   d. Increased awareness of personal vulnerability to alcohol or drug dependency or other problems throughout life;
   e. Attitude changes which support an individual in making low risk choices related to tobacco, alcohol and other drug use during and following pregnancy; and
   f. Developing skills necessary to make and maintain low risk alcohol and other drug choices throughout life.
3. Service limitation. A selective prevention service shall be provided in ¼ hour increments, not to exceed a total of nineteen (19) hours.

20.b. Rehabilitative Services for Pregnant Woman (continued)

(c) Indicated prevention service.

1. Targeted audience: Includes members of the population that do not have a diagnosis of substance abuse or dependency, but do report actually experiencing some problems related to their use of alcohol and drugs.
2. Goals and objectives:
   a. Decreased alcohol and other drug use;
   b. Attitude changes which support an individual in making low risk choices related to alcohol and other drug use;
   c. A greater readiness for and response to treatment for an individual with a substance abuse related diagnosis who is receiving this service as an adjunct to a substance abuse treatment plan; and
   d. Increased skills necessary to make and maintain low risk alcohol and other drug use choices during pregnancy and throughout life.
3. Service limitation. An indicated prevention service shall be provided in ¼ hour increments, not to exceed a total of twenty-seven (27) hours.

(d) Qualifications of providers. All of the prevention services are provided by a Kentucky certified preventionist or a Qualified Substance Abuse Treatment Professional (QSATP) with training in prevention strategies and procedures.

(3) Outpatient services.

(a) Outpatient services may include:

1. Individual therapy;
2. Group therapy;
3. Family therapy. This service is counseling provided to an eligible individual and one (1) or more significant others with the primary purpose of which is the treatment of the individual's condition;
4. Psychiatric evaluation provided by a psychiatrist;
5. Psychological testing provided by a psychologist;
6. Medication management provided by a physician or an advanced registered nurse practitioner; and
7. Collateral care. Involves counseling or consultation services provided directly or indirectly to the recipient through the involvement of a person or person's in a position of custodial control or supervision of the individual in the counseling process. Services are to meet the treatment needs of the eligible individual and shall be a part of the individual's treatment plan. Presence of the recipient in the counseling session is not necessarily required. However, when the recipient is present, reimbursement for the collateral counseling and individual or group counseling for the same session is not allowed.

(b) Service limitations.
1. Group therapy.
   a. There shall be no more than twelve (12) persons in a group therapy session; and
   b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.
2. Collateral care shall be limited to individuals under age twenty-one (21) and no more than four and one-half (4.5) hours of service shall be reimbursed during a one (1) month period.
3. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.

20.b. Rehabilitative Services for Pregnant Woman (continued)

(4) Day Rehabilitation Services.

(a) Shall be an array of substance abuse treatment services in a structured program format that is scheduled to take place multiple hours a day, several times a week and may include individual and group therapy, information on substance abuse and its effects on health, fetal development and interpersonal relationships.

(b) May be covered when provided to an individual in a non-residential setting or as a component of a residential program.

(c) Service limitations:

1. Reimbursement for a day rehabilitation service provided in a non-residential setting shall be limited to no more than 7 hours per day not to exceed twenty (20) hours per week.
2. Reimbursement for a day rehabilitation service provided in a residential setting shall be limited to no more than 8 hours per day not to exceed forty-five (45) hours per week.
3. Payment shall not be made for care or services for any individual who is a patient in an institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.
4. Room and board costs shall not be covered under this benefit.

(5) Outpatient and Day Rehabilitation services shall be provided by a qualified substance abuse treatment professional (QSATP) that meets one of the following requirements:

(a) A certified alcohol and drug counselor; or

(b) An individual who holds a license or certification in medicine, psychology, social work, nursing, marriage and family therapy, professional counselor, or art therapy with 24 hours of additional training in substance abuse or dependency related problems and information specific to working with the target population; or

(c) A bachelor's or greater degree with additional training of 45 hours with 12 hours in substance abuse or dependence related problems, 12 hours specific to the target population, 12 hours in prevention strategies and procedures, and the remaining 9 hours may be in one or more of the identified training topics.

(6) Community support services.

(a) A community support service shall be provided if the service is identified as a need in the individual's treatment plan.

(b) A community support service shall be a face-to-face or telephone contact between an individual and a qualified community support provider.

(c) A community support service shall include:

1. Assisting an individual in remaining engaged with substance abuse treatment or community self-help groups;
2. Assisting an individual in resolving a crisis in an individual's natural environment; and

20.b. Rehabilitative Services for Pregnant Woman (continued)

3. Coaching an individual in her natural environment to:
   a. Access services arranged by a case manager; and
   b. Apply substance abuse treatment gains, parent training and independent living skills to an individual's personal living situation.

(d) A community support provider shall coordinate the provision of community support services with an individual's primary provider of case management services.

(e) Community support staff qualifications.

1. A high school diploma or general equivalent diploma.
2. Two years of supervised experience in substance abuse treatment setting and knowledge of substance abuse related self-help groups.
3. Twenty hours of training on the dynamics and treatment of substance abuse, recovery issues unique to pregnant women and women with dependent children and HIV positive individuals, strategies to defuse resistance, professional boundary issues that address enabling behaviors and protecting a staff member, who may be a recovering substance abuser, from losing their own sobriety.

(7) Reimbursement for a substance abuse service shall not be payable for an individual who is a resident in a Medicaid-reimbursed inpatient facility.

(a) Reimbursement for services shall be based on the following units of service:

1. Universal prevention service shall be a one-quarter (1/4) hour unit;
2. Selective prevention service shall be a one-quarter (1/4) hour unit;
3. Indicated prevention service shall be a one-quarter (1/4) hour unit;
4. Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:
   a. Individual therapy;
   b. Group therapy;
   c. Family therapy;
   d. Psychiatric evaluation;
   e. Psychological testing;
   f. Medication management; and
   g. Collateral care.
5. An assessment service shall be a one-quarter (1/4) hour outpatient unit;
6. Day rehabilitation services shall be a one (1) hour unit;
7. Case management services shall be a one-quarter (1/4) hour unit; and
8. Community support shall be a one-quarter (1/4) hour unit.

(b) Qualifications of Providers

1. Services are covered only when provided by any mental health center, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations.
2. The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
3. A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.

24. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.

A. Transportation

1. Ambulance Services.

(1) Emergency ambulance services shall be provided without preauthorization to and from the nearest hospital emergency room or appropriate medical facility or provider. A statement that the Medicaid recipient received emergency services shall be obtained from the medical personnel of the facility which treated the recipient.

(2) Nonemergency ambulance services to a hospital, clinic, physician's office or other health facility shall be provided if preauthorized. If the Department for Social Insurance local office is closed, the nonemergency ambulance service shall be postauthorized. Preauthorization and postauthorization shall be performed by the Department for Medicaid Services or its authorized representative utilizing criteria shown in Items 2. and 3.

2. Locally Authorized Medical Transportation.

(1) A transportation preauthorization system administered at each local Department for Social Insurance Office shall provide for preauthorized nonemergency transportation approvals, including nonemergency ambulance services, limited to the provision of the services under the following conditions:

(a) the recipient shall be traveling to or from a Medicaid covered service under the state plan, exclusive of pharmaceutical services;

(b) the service shall be determined to be medically necessary;

(c) payment for transportation shall be necessary to ensure that the medical service is secured;

(d) failure to pay for transportation results in a hardship to the Medicaid recipient. A hardship shall not be considered to exist if free transportation which is appropriate for the recipient's medical needs is available or if use of an operational household vehicle is available, appropriate, and is not used for commercial purposes; and

(e) the medical transportation provider, including a private automobile carrier, has a signed participation agreement with the Department for Medicaid Services.

(2) Locally authorized medical transportation shall be provided as necessary on an exceptional postauthorization basis with the additional limitation that the postauthorization shall be justified by the recipient indicating the need for medical transportation arose and was provided outside normal working hours and that payment for the transportation has not been made.

3. Determination of Necessity.

(1) All approvals for nonemergency transportation services and the provision of preauthorization and postauthorization, shall be made by the Department for Medicaid Services or by the Department's authorized representative.

(2) Only transportation within the medical service area shall be approved. Transportation services provided outside the medical service area shall be approved by the Department for Medicaid Services or the Department's authorized representative if the medical service required by the recipient is not available in that area and the recipient has been appropriately referred by a local medical provider.

(3) Only the least expensive available transportation suitable for the recipient's needs shall be approved.

23.d. Nursing Facility Services for Patients Under 21 Years of Age

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is involved to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

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CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate.

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
   (a) assessment
   (b) care/services plan development
   (c) linking/coordination of services
   (d) reassessment/followup
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.

2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for Severely Emotionally Disturbed Children

A. Target Groups: By involving the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Age 0-21 and meet the state's conditions and circumstances to be defined as a "severely emotionally disturbed child."

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provide services less than statewide:

C. Comparability of Services

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section (1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(1) A written comprehensive assessment of the child's needs;
(2) Arranging for the delivery of the needed services as identified in the assessment;
(3) Assisting the child and his family in accessing needed services;
(4) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing needs;
(5) Performing advocacy activities on behalf of the child and his family;
(6) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
(7) Providing case consultation (i.e., consulting with the service providers/collateral's in determining child's status and progress); and
(8) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Provider participation shall be limited to the Kentucky Department for Social Services and the fourteen Regional Mental Health Mental Retardation Centers, licensed in accordance with state regulations.

Qualification of Case Manager and Supervision Requirement

(1) Case Manager Qualifications. Each case manager shall be required to meet the following minimum requirements:

(a) Have a Bachelor of Arts of Bachelor of Sciences degree in any of the behavioral sciences from an accredited institution; and

(b) Have one (1) year of experience working directly with children or performing case management services (except that a master's degree in a human services field may be substituted for the one (1) year of experience); and

(c) Have received training within six (6) months designed and provided by each participating provider directed toward the provision of case management services to the targeted population; and

(d) Have supervision for a minimum of one (1) year by a mental health professional; i.e., psychiatrist, psychologist, master's level social worker (MSW), psychiatric nurse or professional equivalent (a minimum of a bachelor's degree in a human services field, with two (2) years of experience in mental health related children's services). The supervisor shall also complete the required case management or training course.

(2) Case Manager Supervision Requirement. For at least one (1) year, each case manager shall have supervision performed at least once a month for each case plan.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the providers of case management services.

(2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purposes.

Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and

2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.

B. Areas of State in which services will be provided:

_X_ Entire State.

____ Only in the following geographic areas (authority of Section 1915(g)(1) of the act is invoked to provide services less than statewide):

C. Comparability of Services

___ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(l) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(1) A written assessment of the child or adult's needs;

(2) Arranging for the delivery of the needed services as identified in the assessment;

(3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult;

(4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;

(5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs;

(6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc. following provision of service to the child or the adult on behalf of the child or adult;

(7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and

(8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

(1) Demonstrated capacity to provide all core elements of case management including
(a) assessment;
(b) care/services plan development;
(c) linking/coordination of services; and
(d) reassessment/follow-up.

(2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations.

(3) Demonstrated experience with one of the target populations.

(4) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(5) A financial management system that provides documentation of services and costs.

(6) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(7) Demonstrated ability to assure a referral process consistent with Section 1902(a)(23) of the Act, freedom of choice of provider.

(8) Demonstrated capacity to meet the case management service needs of one of the target populations.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

(1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
(2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the providers of case management services.
(2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 Participating in the Kentucky Early Intervention Program

A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

X Entire State

__ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:

C. Comparability of Services

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with on-going service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

(1) Assessment of child's medical, social and functional status and identification of service needs;
(2) Initial service coordination from notice of referral through initial IFSP development;
(3) Assuring that all procedural safeguards are met during intake and IFSP development;
(4) Arranging for and coordinating the development of the child's IFSP;
(5) Arranging for the delivery of the needed services as identified in the IFSP;
(6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
(7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
(8) Performing activities to enable an eligible individual to gain access to needed services;
(9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
(10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

(11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and

(12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915(g)(1) of the Social Security Act, qualified providers shall be the Title V agency, the Department for Mental Health and Mental Retardation Services, and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:

a) assessment;

b) care/services plan development;

c) linking/coordination of services; and

d) reassessment/follow-up.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;

3. Demonstrated experience with the target population;

4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and

5. A financial management system that provides documentation of services and costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

A. Have a Bachelor's degree; and
(1) 2 years experience in service coordination for children with disabilities up to age 18; or
(2) 2 years experience in service provision to children under six years of age; or

B. Meet one of the following professional criteria:

1. Audiologist - Licensed or Certified,
2. Family Therapist - M.A. and Certified,
3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
4. Developmental Associate,
5. Registered Nurse,
6. Advanced Registered Nurse Practitioner,
7. Dietitian - Licensed,
8. Occupational Therapist - Licensed,
9. Occupational Therapist Assistant - B.S. and Licensed,
10. Orientation and Mobility Specialist - Certified,
11. Physical Therapist - Licensed,
12. Psychologist - Licensed or Certified,
13. Speech Language Pathologist - Licensed or Certified,
14. Speech Language Assistance - Licensed,
15. Social worker - Licensed,
16. Physician, Licensed,
17. Nutritionist, Licensed

F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the available providers of case management services.

(2) Eligible recipients will have free choice of the available providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Pregnant women who have not reached their twentieth birthday and will be first time teen parents;
2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program, Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed; inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.

B. Areas of State in which services will be provided:

X Entire State

_ Only in the following geographic areas (authority of Section 1915(g)(1)of the Act is involved to provided services less that state wide:

C. Comparability of Services:

_ Services are provided in accordance with 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).

D. Definition of Services

Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the

requirement of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment

   a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;

   b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:

      1) parent's childhood experience;

      2) lifestyle behaviors and mental health status;

      3) parenting experience;

      4) stressors, coping skills and support system for the new family;

      5) anger management skills;

      6) expectations of infant's developmental milestones and behaviors;

      7) perception of new infant, and bonding and attachment issues;

      8) plans for discipline; and

      9) family environment and support system.

   c) Develops a written report of the findings and a service plan for the family.

   d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

2. Home Visitation

a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker, or early childhood development specialist may perform a home visit;

b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;

c) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;

d) Perform activities to enable the child and family to gain access to needed services;

e) Prepare and maintain case records documenting contacts, services needed, reports, progress;

f) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and

g) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

1. Providers must be certified as a Medicaid provider meeting the following criteria:

a) Demonstrated capacity to contract statewide for the case management services for the targeted population;

b) Demonstrated capacity to ensure all components of case management including;
   1) screening,
   2) assessment,
   3) treatment plan development,
   4) home visiting,
   5) linking/coordination of services, and
   6) follow-up and evaluation;

c) Demonstrated experience in coordinating and linking such community resources as required by the target population;

d) Demonstrated experience with the target population;

e) Administrative capacity to insure quality of services in accordance with state and federal requirements;

f) Demonstrated capacity to provide certified training and technical assistance to case manager;

g) Financial management system that provides documentation of services and costs;

h) Capacity to document and maintain individual case records in accordance with state and federal requirements;

i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and

j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

a) Registered Nurse – Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.

b) Social Worker – Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.

c) Early Childhood Development Specialist – have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.

d) Family Support Worker (FSW) – Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, HIV/AIDS training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the available providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

I. Standards designed to assure high quality care are described as follows:

Standards governing the provision of provider services have been established for each provider group covered under the Program. The established standards have been reviewed and evaluated and in part developed by the respective health professional groups and subsequently recommended by the Technical Advisory Committees and the Advisory Council for Medical Assistance. The following basic standards apply to all providers who participate in the Program:

A. Vendor licensure
B. Vendor participation authorization
C. Vendor claim certification

In addition to these basic standards, specific standards have been developed for the providers of the various levels of institutional care to assure that the care and services rendered to patients is in accordance with the health and medical care needs of the patients.

Standards have also been established for providers of non-institutional services such as home health agencies, independent laboratories, community mental health centers, pharmacies, screening clinics, family planning clinics and ambulance transportation services. These standards cover such elements as administration, staffing/treatment plans, and fiscal plant.

Individual providers of health and medical care service, such as physicians, dentists, optometrists, ophthalmic dispensers, audiologists, and hearing aid dealers are required to meet the respective acceptable standards of health and medical practice within the community.

II. Methods of assuring high quality care are described as follows:

A. Systematic surveillance of services rendered

1. Development of comprehensive utilization review programs for each service element of the Program.

2. Periodic review of the kinds, amounts and durations of medical care received by all Program recipients

3. Periodic review of the medical practices of all individuals, practitioners, agencies and institutions

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4. On-site visits to evaluate the kinds of medical care provided to Program recipients

5. Involvement of health care and medical professionals in the review and analysis of exceptions within the system.

B. Identification of recipients who inappropriately utilze the pharmacy and physician benefits of the Program. Through an intensified patient education program and pre-selection of providers by these recipients, an effort is made to improve the utilization patterns of these recipients.

C. On-site visits to medical institutions by a medical review team to evaluate the care and services provided to Program recipients. These teams are composed of at least a physician, a nurse, and a social worker.

D. Methods exist that assure that direct service workers and their supervisors are knowledgeable about health problems and ways to assist people to secure medical and remedial care and services.

E. Close scrutiny of all provider claim forms is performed by paramedical personnel and medical professionals to assure that the service rendered was in accordance with accepted norms of practice for the specific condition indicated.

F. The Program requires that providers of service be in compliance with established standards as a prerequisite to enrollment as a provider under the Program. Continuous compliance with established Program standards is determined through a process of periodic on-site surveys and evaluations of facilities and services.

Transportation (For Categorically Needy and Medically Needy)

A. The Department for Medicaid Services assures that medically necessary transportation of recipients to and from providers of service will be provided. The methods that will be used are as follows:

1. Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services such as fire department and public ambulances, or relatives will be used.

2. If transportation is not available without charge, payment will be made for the least expensive means of transportation suitable to the recipient, whenever determined to be medically necessary through preauthorization, postauthorization, or through the patient's meeting certain specified criteria relating to destination, point of departure, and condition.

3. When transportation is required on a predictable basis, an amount to cover the transportation is allowed as a spenddown by the medically needy.

4. When medical transportation is required, a preauthorization system at the local level is used for nonemergency transportation.

5. Payments for locally authorized medical transportation shall be made directly to participating providers by the Medicaid Program.

6. All Medicaid participating medical transportation providers, including private automobile carriers, shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing the medical transportation service.

7. Locally authorized medical transportation shall be provided on an exceptional postauthorization basis for nonemergency, medically necessary transportation under the following conditions: the client can justify the need for medical transportation arose and was provided; was provided outside the normal working hours; payments for the transportation has not been made; client was traveling to or from a medical service covered under the state plan, except for pharmaceutical services; and service was determined medically necessary by the state agency.

B. Ambulance service shall be reimbursable only when it is the least expensive and most appropriate for the recipient's medical needs and the following criteria shall be met.

1. Emergency ambulance services to the nearest appropriate medical facility are provided without preauthorization when the emergency treatment is specified and rendered.

2. Nonemergency ambulance services to a hospital, clinic, physician's office, or other health facility to secure medically necessary Medicaid covered services for a Medicaid recipient.

3. Any determination of medical necessity of transportation, and provision of preauthorization and postauthorization, is made by the Department for Medicaid Services or by the Department's authorized representative. Transportation only within the medical service area is approved unless preauthorized by the agency (or postauthorization in certain instances), unless previously designated criteria for transportation not requiring authorization are met.

State/Territory: Kentucky

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

General Coverage Criteria. The following general coverage criteria shall be applicable with regard to organ transplants.

1. For an organ transplant to be covered under the Medicaid Program, it must be the opinion of the transplant surgeon that the transplant is medically necessary; the failure to perform the organ transplant would create a life-threatening situation; and the prognosis must be that there is a reasonable expectation the transplant will be successful and result in prolonged life of quality and dignity.

2. The hospital and physician performing the transplant must be recognized by the Medicaid Program as being competent to perform the transplant. A staff and functioning unit at the hospital designed for and/or accustomed to performing transplants of the nature envisioned, recognized as competent by the medical community, will ordinarily be considered competent by the program.

Reimbursement for Organ Transplants. Hospital payments for organ transplants will be set at eighty (80) percent of actual usual and customary charges with total payments not to exceed $75,000 per transplant without regard to usual program limits on hospital length-of-stay. An exception to the maximum payment limit can be made by the Commissioner, Department for Medicaid Services on a case by case basis when the maximum payment limit restricts medically appropriate care or prohibits the availability of the needed transplant procedure or service. Physician payments for organ transplants will be at the usual Medicaid Program rates.

Application of Organ Transplants Policy. It is the intent of the Department for Medicaid Services that the organ transplant policy be applied uniformly and consistently so that the similarly situated individuals will be treated alike. To accomplish this goal the Department will use the methodology specified in this section in receiving and processing requests for coverage and payments for organ transplants.

1. All requests for authorization for organ transplants must be sent to the Commissioner, Department for Medicaid Services.

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2. The Commissioner will assign the request to appropriate staff for investigation, report and recommendation. The report must show whether the person requesting the transplant is Medicaid eligible (or approximately when the person will become eligible); the type of transplant requested; the name of the facility (and physician if considered necessary) where the transplant is to be performed; any fee arrangement that has been made with the facility and/or physician (or a statement as to whether there is a disagreement with regard to fees); the proposed date of the transplant; the prognosis; a finding as to whether the facility/physician is considered qualified for the transplant being considered; and a finding as to whether program criteria for coverage is met.

3. After consideration of the report and recommendation, the Commissioner will determine whether the general coverage criteria are met and payments for the transplant should be made. If the decision is to provide coverage, Medicaid Program staff will assist the recipient with necessary arrangements for the transplant. If the decision is negative, the recipient will be notified of the manner in which the request does not meet agency guidelines.

Scope of Coverage. This organ transplant policy is applicable with regard to the following types of transplant: heart, lung, bone marrow and liver. Other types of transplants will also be covered under this policy upon identification and request except when special treatment of the transplant services is not considered necessary (i.e., usual program coverage and reimbursement is considered adequate), or when the transplant is considered by the Department for Medicaid Services to be experimental in nature. The Medicaid Program will not cover experimental transplants, i.e., those which have not previously been proven effective in resolving the health problems for which the transplant is the proposed preferable treatment mode.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Kentucky

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. [X] Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [X] No [ ]

2. [ ] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [ ] No [ ]

3. [ ] All individuals eligible under the State's approved title XIX plan.

4. [X] Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Eligible categorically needy individuals

3. Eligible medically needy individuals